STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES
MEDICAID PROGRAM

CERTIFICATE OF MEDICAL NECESSITY for ENTERAL NUTRITION

Instructions:

1. DME PROVIDER RESPONSIBLE FOR SUBMISSION OF COMPLETED FORMS & ASSOCIATED DOCUMENTS
2. DME PROVIDER TO ATTACH RI MEDICAL ASSISTANCE PA FORM
   HTTP://WWW.EOHHS.RI.GOV/PORTALS/0/UPLOADS/DOCUMENTS/PA_FORM.PDF
3. DME PROVIDER TO MAIL ORIGINALS TO:
   HP ENTERPRISE SERVICES
   POB 2010, WARWICK, RI 02887

SECTION A: TO BE COMPLETED BY DME PROVIDER . PLEASE PRINT INFORMATION.

RECIPIENTS NAME: _____ TODAY'S DATE: ___/___/_____

MEDICAL ASSISTANCE ID NUMBER: _____

DME PROVIDER NAME: _____

DME PROVIDER CONTACT NAME: _____ PHONE: _____

PRINT ORDERING PRESCRIBER'S NAME: _____

DESCRIPTION OF ITEMS BEING REQUESTED	HCPCS CODE	MODIFIER	CALORIES PER DAY	UNITS PER DAY	# OF MONTHLY REFILLS	LENGTH OF NEED

DME Provider SIGNATURE_____ **DATE** _____

BY SIGNING THIS FORM, THE DME PROVIDER CONFIRMS THE INFORMATION ON THIS FORM AS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

CONTACT HP ENTERPRISE SERVICES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

SECTION B: TO BE COMPLETED OR REVIEWED AND SIGNED BY PRESCRIBER. PLEASE ATTACH ANY SUPPORTING MEDICAL DOCUMENTATION AS NECESSARY.

RECIPIENTS NAME: _____ BMI: _____

PRESCRIBER NAME: _____

CONTACT NAME (IF DIFFERENT): _____ PHONE: _____

Determination of medical necessity for enteral products shall be based upon a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the product, including but not limited to the information below.

HOW IS TREATMENT PROVIDED?

☐ Mouth (oral) only ☐ Nasogastric (NG-tube) ☐ Gastric (G-tube) ☐ Jejunal (J-tube)

ISTHIS THE SOLE SOURCE OF NUTRITION? ☐ Yes ☐ No

WEIGHT LOSS THAT PRESENTS ACTUAL OR POTENTIAL FOR DEVELOPING MALNUTRITION:

ADULTS:

☐ Involuntary or acute weight loss equal to or greater than 10% of usual body weight over a 3 to 6 month period, **OR**

☐ A Body Mass Index (BMI) below 18.5, **OR**

☐ A diagnosis of inborn errors of metabolism that require medically necessary formula used for specific metabolic conditions.

DIAGNOSIS CODE - Please provide the appropriate Diagnosis Code(s)

PRESCRIBER SIGNATURE_____ **DATE** _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

ADDITIONAL PRESCRIBER COMMENTS: